Quarterly Doses Administered Report

For **FQHC/RHC Provider** use

1. VFC PIN #

2. Provider or Clinic Name:		Phone #:
Name of Person Submitting Form:		Quarter / Year:
3. I certify under penalty of law that the below information is true.	Signature:	Date:

Instructions for Completing the Quarterly Doses Administered Report

Complete and submit this form to the Utah VFC Program within 15 days following the end of each quarter.

1st quarter:	*January, February, March*	Due **April 15th**
2nd quarter:	*April, May, June*	Due **July 15th**
3rd quarter:	*July, August, September*	Due **October 15th**
4th quarter:	*October, November, December*	Due **January 15th**

1. Enter VFC Pin #. (Verify if unsure of correct number.)
2. Print the name of clinic, phone number, quarter and year of this report, and name of the person completing this form.
3. Read the attestation statement, sign and date.
4. On the Total Number of Immunization Visits or Encounters table, enter the number of individuals who received vaccines, *counted by visit/encounter*, in the proper age and eligibility categories. **Total** each row and column.
5. Page two (reverse side), print name of clinic and VFC Pin # in top boxes. (When faxed, pages are separated.)
6. On the Total Number of VFC Doses Administered table, enter the number of doses administered to VFC eligible children, by age and vaccine type. **Total** each row and column.
7. On the Total Number of CHIP Doses Administered table, enter the number of doses administered to CHIP enrolled children, by age and vaccine type. **Total** each row and column.

Use of Doses Administered *Tally Sheet* is Optional.
Please do NOT return *Tally Sheets*.

Mail or fax the Quarterly Doses Administered Report to:

Utah Department of Health
Immunization Program
PO Box 142001
Salt Lake City, UT 84114-2001
(801) 538-9450
FAX: (801) 538-9440

4. Total Number of Immunization **Visits or Encounters**						
Age	**Vaccines for Children (VFC)**				**State Supplied**	**Total**
	Am. Indian / Alaskan Nat.	Medicaid	Non-insured	Underinsured	CHIP	
<1						
1-6						
7-18						
>18						
Total						

➔Continue on back

5. Provider or Clinic Name:	VFC PIN #

6. Total Number of **VFC Doses** Administered																						
Age	DTaP	DT	Td	Tdap	DTaP/ HepB/ IPV	DTaP/ HIB	HIB	IPV	MCV4	MMR	Hep B Ped	Hep B Adult	Hep B /HIB	Hep A Ped	Hep A Adult	Var	MMRV	PCV7	PPV23	Flu	RTV	HPV	**Total**
<1																							
1-6																							
7-18																							
>18																							
Total																							

6. Total Number of **CHIP Doses** Administered (State Supplied)																						
Age	DTaP	DT	Td	Tdap	DTaP/ HepB/ IPV	DTaP/ HIB	HIB	IPV	MCV4	MMR	Hep B Ped	Hep B Adult	Hep B /HIB	Hep A Ped	Hep A Adult	Var	MMRV	PCV7	PPV23	Flu	RTV	HPV	**Total**
<1																							
1-6																							
7-18																							
>18																							
Total																							